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Recruitment of Physicians for the Active Army, 1970-1980

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Final report 6 June 1975

1 OCT 1975

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A thesis presented to the faculty of the U.S. Army Command and General Staff
College, Fort Leavenworth, Kansas 66027



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SECURITY CLASSIFICATION OF THIS PAGE (When Data Entered)

REPORT DOCUMENTATION PAGE		READ INSTRUCTIONS BEFORE COMPLETING FORM
1. REPORT NUMBER	2. GOVT ACCESSION NO.	3. RECIPIENT'S CATALOG NUMBER
4. TITLE (and Subtitle) Recruitment of Physicians for the Active Army, 1970-1980		5. TYPE OF REPORT & PERIOD COVERED Final report 6 Jun 75
		6. PERFORMING ORG. REPORT NUMBER
7. AUTHOR(s) Vance, William M., MAJ, USA		8. CONTRACT OR GRANT NUMBER(s)
9. PERFORMING ORGANIZATION NAME AND ADDRESS Student at the U.S. Army Command and General Staff College, Fort Leavenworth, Kansas 66027		10. PROGRAM ELEMENT, PROJECT, TASK AREA & WORK UNIT NUMBERS
11. CONTROLLING OFFICE NAME AND ADDRESS US Army Command and General Staff College ATTN: ATSW-DD Fort Leavenworth, Kansas 66027		12. REPORT DATE 6 Jun 75
		13. NUMBER OF PAGES 50
14. MONITORING AGENCY NAME & ADDRESS (if different from Controlling Office)		15. SECURITY CLASS. (of this report) Unclassified
		15a. DECLASSIFICATION/DOWNGRADING SCHEDULE 1 OCT 1975
16. DISTRIBUTION STATEMENT (of this Report) Distribution limited to U.S. Government agencies only: Proprietary Information. Other requests for this document must be referred to U.S. Army Command and General Staff College, Fort Leavenworth, Kansas 66027.		
17. DISTRIBUTION STATEMENT (of the abstract entered in Block 20, if different from Report)		
18. SUPPLEMENTARY NOTES Master of Military Art and Science (MMAS) Thesis prepared at CGSC in partial fulfillment of the Masters Program requirements, U.S. Army Command and General Staff College, Fort Leavenworth, Kansas 66027		
19. KEY WORDS (Continue on reverse side if necessary and identify by block number)		
20. ABSTRACT (Continue on reverse side if necessary and identify by block number) See reverse.		

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SECURITY CLASSIFICATION OF THIS PAGE(When Data Entered)

The Army Medical Department method of procuring physicians is examined from several aspects: (1) an historical review of physician procurement during the 1940-1973 draft period with an expiration of draft dependent programs; (2) the Army procurement plan as a forecast of anticipated requirements and the need for volunteer physicians to offset the loss of the draft and draft-motivated programs; (3) the current Army procurement system and its supporting assets including the personnel counselor system and contract advertising capabilities; and, (4) comparison of physician procurement techniques used by military and civilian recruitment agencies.

Conclusions drawn after examining the history of physician procurement, the current national situation regarding physician manpower, and the projected needs of the Army coupled with available assets that can be devoted to procurement are as follows:

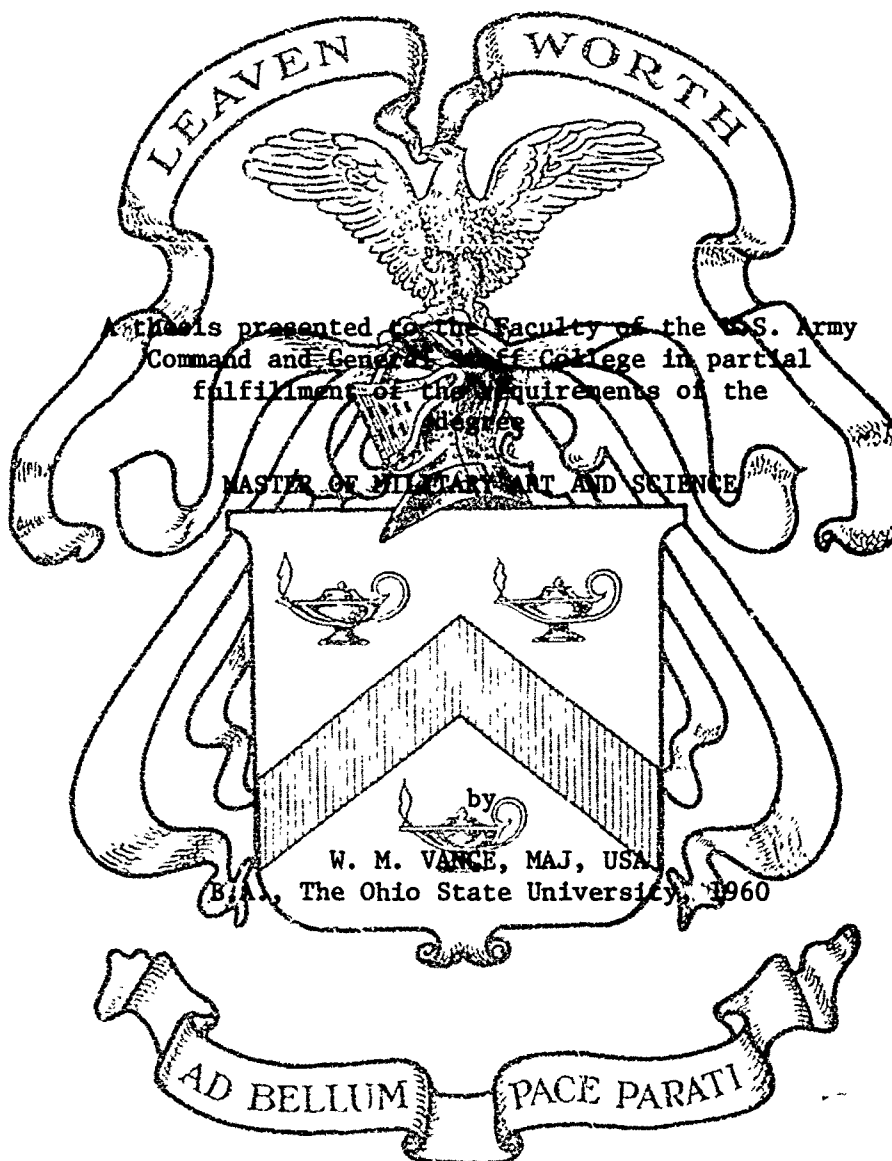
1. The Army is forced to compete for physicians.
2. It has a relatively well-developed and supported procurement effort dedicated to scholarship and medical student programs, but not to the qualified volunteer physician.
3. Army Medical Department conservatism and sensitivity to any criticism directed toward recruitment efforts has inhibited the use of available assets to include common commercial advertising techniques.
4. Stress is placed on the potential for increased procurement performance if available assets are effectively used.

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RECRUITMENT OF PHYSICIANS FOR THE ACTIVE ARMY

1975-1980



Fort Leavenworth, Kansas
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ABSTRACT

The Army Medical Department method of procuring physicians is examined from several aspects: (1) an historical review of physician procurement during the 1940-1973 draft period with an expiration of draft dependent programs; (2) the Army procurement plan as a forecast of anticipated requirements and the need for volunteer physicians to offset the loss of the draft and draft-motivated programs; (3) the current Army procurement system and its supporting assets including the personnel counselor system and contract advertising capabilities; and, (4) comparison of physician procurement techniques used by military and civilian recruitment agencies.

Several conclusions are drawn after examining the history of physician procurement, the current national situation regarding physician manpower, and the projected needs of the Army coupled with available assets that can be devoted to procurement. The Army is forced to compete for physicians. It has a relatively well-developed and supported procurement effort dedicated to scholarship and medical student programs, but not to the qualified volunteer physician. Army Medical Department conservatism and sensitivity to any criticism directed toward recruitment efforts has inhibited the use of available assets to include common commercial advertising techniques.

Stress is placed on the potential for increased procurement performance if available assets are effectively used.

TABLE OF CONTENTS

	Page
THESIS APPROVAL PAGE	ii
ABSTRACT	iii
LIST OF FIGURES	vii
CHAPTER	
I. ARMY PHYSICIAN PROCUREMENT 1940-1974	1
INTRODUCTION	1
DEFINITIONS	2
CONSCRIPTION	4
PROCUREMENT PROGRAMS	8
OPPORTUNITIES FOR CONTINUED EDUCATION	13
THE VOLUNTEER	13
ENDNOTES	17
II. PROJECTED REQUIREMENTS FOR PHYSICIANS PROCURE- MENT PLANNING	19
THE MEDICAL PROCUREMENT PLAN 1975-80	21
ENDNOTES	26
III. THE ARMY MEDICAL DEPARTMENT PROCUREMENT SYSTEM	27
THE ARMY MEDICAL DEPARTMENT (AMEDD) PERSONNEL COUNSELOR	27
COUNSELOR FIELD OPERATIONS	28
ADVERTISING CAMPAIGNS AND MATERIALS	30

CHAPTER	Page
ATTITUDES	32
ENDNOTES	35
IV. CIVILIAN PHYSICIAN PROCUREMENT	36
THE MEDICAL COMMUNITY TODAY	36
THE PLACEMENT AGENCY	37
TECHNIQUES AND MATERIALS	38
INCENTIVES	39
PRODUCTIVITY	40
CONCLUSIONS	40
ENDNOTES	41
V. CONCLUSIONS AND RECOMMENDATIONS	42
CONCLUSIONS	42
RECOMMENDATIONS	46
BIBLIOGRAPHY	48

LIST OF FIGURES

Figure	Page
1. Army Medical Corps Procurement Plan FY75-80 (Straight Lined at FY77 Authorization Level)	22
2. Army Medical Corps Procurement Plan FY75-80 (Reflects Annual 2 Percent Decrease in Authorization Level)	23

CHAPTER I

ARMY PHYSICIAN PROCUREMENT

1940-1974

INTRODUCTION

June 14, 1775, the Continental Congress resolved to raise an army.¹ Soon thereafter, the first physicians were recruited to provide health care for the Continental Army. During the past three decades, physician recruitment has been based upon the required military service imposed by the draft. The draft has passed into history, at least for the foreseeable future, and it is now necessary to recruit physicians from contemporary society for Army service.²

It is the purpose of this study to examine current Army Medical Department procurement policies, procedures, and techniques and to determine their adequacy to meet the requirements for volunteer physicians for the period 1975-1980. To accomplish this, it is necessary to examine the history of Army physician procurement and the techniques the civilian health community uses to place physicians.

Sources the author has examined include pertinent publications, U.S. Army regulations, Congressional documents, and Army staff working papers. In addition, the personal observations and experiences of the author are cited.

The author served in the Office of the Surgeon General, Directorate of Personnel, Officer Procurement Division, April 1970 - July 1974. During this period he was assigned as Chief, Medical Corps-Dental Corps Branch and later as Special Actions Officer and Chief Policy and Plans Officer. The author was legislative monitor and project officer of the Armed Forces Health Professions Revitalization Act of 1972 and represented the Army as a member of the Department of Defense Tri-Service Ad Hoc Committee charged with the implementation of the Armed Forces Health Professions Scholarship Program. He also was action officer responsible for the Army Medical Department (AMEDD) advertising program from early 1972 until his reassignment in July 1974. In addition to his staff experience at the Office of the Surgeon General, the author served as AMEDD Personnel Counselor in Philadelphia, Pennsylvania, July 1965 - July 1968, and conducted procurement activities in eastern Pennsylvania, Delaware, New Jersey, and Metropolitan New York (including Long Island).

DEFINITIONS

Certain definitions must be established as follows:

Physician. A graduate of a school of medicine or osteopathy which is recognized by the World Health Organization and who is licensed, or eligible for unrestricted licensure, to practice medicine and surgery in one of the 50 United States, the District of Columbia, or the Commonwealth of Puerto Rico.

This definition is in general use by all federal agencies. The foreign medical graduate meets this criteria after he receives the Educational Certificate for Foreign Medical Graduates (ECFMG) issued by a committee of the American Medical Association (AMA) based upon a written examination.

Volunteer. An individual who freely applies for commissioned appointment and active duty as an officer of the Army Medical Corps. The volunteer must be unencumbered (i.e., under no contractual or statutory obligation to serve) and meet the criteria for professional qualification as well as the eligibility requirements for commissioned appointment in one of the components of the Active Army.

Medical Education. Medical education, in the sense of this study, begins with admission to medical school and continues through internship and residency training. This, in turn, leads to eligibility for certification by one of the specialty boards of the AMA or the American Osteopathic Association (AOA). All medical graduates normally complete a 12 month internship and most continue to specialty qualification in a residency or fellowship program. Residencies vary in length depending upon the requirements of the specialty board with the shorter being two years, e.g., psychiatry, family practice, and the longer programs extending to seven or more years, e.g., neurosurgery, thoracic surgery. In a recent trend in medical education, the residency program has become a continuation of the intern year or even the final year of medical school;

thus, the distinction between internship and residency is more vague. In some cases, specialty training may begin before graduation from medical school. Approximately one-third of the nation's medical schools offer a three year program rather than the classical four year program. However, the three year program generally provides the same number of class hours as the four year course and simply omits the vacation periods.

CONSCRIPTION

Prior to World War II there were three avenues by which a physician could enter the active Army: (1) as a volunteer; (2) as a voluntarily or involuntarily activated Reserve or National Guard Officer; and, (3) as a member of a Reserve or National Guard unit activated for duty.²

Congress recognized the growing threat of global war and, by a narrow margin, enacted the Selective Service Act of 1940 on September 16, 1940.³ This law established a statutory obligation for physically fit male Americans who were selected by their local Selective Service boards to serve as members of the Armed Forces. There were no provisions for the designation of special categories of occupational skills. However, the local boards were responsible for balancing the needs of the armed services with the needs of the community and local industry in supporting both the war effort and the nation.^{4,5} Individuals selected for induction were allocated

to one of the Armed Services and enlisted in the lowest enlisted grade. Selective service policy permitted persons of unusual qualifications or skills (scientists, individuals with prior commissioned service, physicians) to volunteer for service in a commissioned status, but the bulk of the junior officers entered the service after having been trained and commissioned through either the Army ROTC program or Officer Candidate School.

World War II was a "popular" war and had the support of a nation which firmly sensed it was serving justice. The procurement of medical officers was not a significant problem. Most physicians volunteered and very few were inducted as enlisted men and fewer still refused to accept commissioned status to practice their profession in the Armed Forces.² Problems were experienced in pacing the input of physicians to meet the needs of the active forces and concurrently to satisfy the health needs of the civilian population.⁶ The Procurement and Assignment Service was, therefore, created in November 1941. It had the unique function of assuring continuance of adequate civilian medical care by determining civilian needs and restricting military physician recruitment should civilian requirements not be met.

Thousands of physicians returned to civilian life upon demobilization after World War II. Some retained their reserve commissions by choice; others, having served less than 13 months on active duty, were required to retain their

reserve appointments for a period of time after demobilization.

In 1947, the Selective Service Act of 1940 expired and was not renewed. Flagging enlistments in the face of the Cold War forced Congress to enact the Selective Service Act of 1948⁷ for a two-year period which was, in turn, extended in June 1950, as the Selective Service Act of 1950. This was not a routine reenactment, but an issue of some controversy. The 1948 act expired in June 1950. A 15 day extension was enacted to permit continuation of the debate. The extension was scheduled to expire July 9, 1950; however, the 25 June communist invasion of South Korea realigned the priorities of the Congress and the Selective Service Extension Act of 1950 was rapidly enacted.⁸

Physician mobilization for the Korean conflict was difficult. Korea was not a popular cause. Reserve forces were activated and many of the reservists were physicians who had served for a short time at the end of World War II and who had been forced to retain reserved commissioned status. These officers were resentful at being called for a second time from established civilian practices while those who had completed their basic medical education from 1945 to 1950 had never been called to serve.⁶ Although emotions were high and resentments deep, it must be noted that the vast majority of these officers responded to the active duty call and served well until they were discharged.²

The Army recognized that physician procurement to support the Korean conflict would be a problem and, based upon the recommendations of the Secretary of Defense, Congress enacted PL 779 "The Doctor Draft,"⁹ September 9, 1950. This Act was essentially an amendment to the Selective Service Act of 1948 and required local boards to register and classify physicians (MD's only, osteopaths were not included at this point) separately, subject to special call. PL 779 was not effective until January 1, 1951, but the procurement problem was becoming most pressing. The President, therefore, implemented the provisions of the Act by Proclamation 2906, "Special Registrants," October 6, 1950.

A general revamping of the Selective Service System was directed by the Congress in the enactment of the Universal Military Training and Service Act of 1951.¹⁰

In the next session, PL 83-84 established the Selective Service procedures for physicians.¹¹ Subsequent legislation further clarified the position of the physician and the draft. A major loophole was closed when PL 83-403 authorized the conscription of physicians in an enlisted status with utilization within their profession should they refuse to accept an offered commission. Some physicians had attempted to skirt the draft by refusing to accept the offered commission relying on the Army's statutory inability to use physicians in other than commissioned status and Selective Service's statutory inability to call them to duty in any

status other than that of physician.¹² A series of extensions continuing the basic provisions of the Selective Service Act were enacted as required. The draft annually continued to meet the requirements of the active force until expiration of the President's authority to issue orders for induction, June 30, 1973.

From the mid-1950's through the end of the draft in 1973, the young physician could anticipate serving on active duty for a two-year period immediately after internship. This was a routine part of his career pattern unless he had made arrangements with his local draft board to adjust his entry on active duty to a mutually satisfactory time. The bulk of all eligible physicians served. By 1966 osteopaths were liable for induction as physicians and women physicians also were encouraged to volunteer.

PROCUREMENT PROGRAMS

Procurement programs are set "packages" of options which provide incentives or avenues leading to active commissioned service as an Army medical officer. This section presents a discussion of current and past programs which affect current physician procurement. These programs include the Early Commissioning Program; The Clinical Clerkship Training Program; The Senior Medical and Osteopathic Student Program; The Berry Plan; The Armed Forces Health Professions Scholarship Program; The Program for Medical, Dental, and

Veterinary Education for Army Officers, and the Army Medical Internship and Residency Programs.

The Early Commissioning Program stems from the era of the 1940 Selective Service Act and is the oldest procurement program. Participants were matriculated students of medicine who accept commissioned appointment in the inactive reserve in return for a commitment to serve on active duty as a medical officer after completing their professional educations. The primary benefit to the individual was that his commissioned status precluded his induction through the regular draft and assured him of an uninterrupted professional education and utilization within that profession upon entry on active duty. The program is still in effect, although at present, it is used as a vehicle to facilitate commissioned appointment required for participation in other programs (e.g., clinical clerkship).¹³

The Clinical Clerkship Training Program offers the student an opportunity to view Army medicine on site as a reserve officer (having received his commission through the Early Commissioning Program or the Army ROTC program) while on active duty or as a civil service employee for 15-60 day periods during vacation from medical school. Participants serve as clinical clerks (also known in the civilian community as externs or preceptors) in Army teaching hospitals. This "sampler" is a successful recruiting device for the Army internship program. It allows the Army to evaluate prospective

applicants while the student, in turn, evaluates the program. The student/officer incurs no obligation for participation in the clerkship program.¹⁴

For many years the Senior Medical Student Program was the only Army program that provided significant financial assistance. Selected participants were commissioned through the Early Commissioning Program, although some already held ROTC appointments. They were called to active duty for the last twelve months of their medical education, but remained in their civilian schools and drew active duty pay and allowances as well as other active service benefits. "Pay back" was three years active duty as a medical officer immediately following internship. Competition for the program was intense and a maximum of 125 students were selected annually. The need for the program was reduced with the implementation of the Armed Forces Health Professions Scholarship Program. The Senior Medical Student Program will be terminated with the graduating class of 1975.¹⁵

The most significant draft-motivated program was the Armed Forces Physicians Residency Consideration Program. It was known universally as the "Berry Plan" and was named after its originator, Dr. Frank Berry, MD, an early Assistant Secretary of Defense (Health and Environment). The Berry Plan served the best interests of almost two decades of medical graduates and the armed forces by recognizing two

facts: (1) young physicians fervently desired to continue their professional educations without interruption; and (2) the armed forces had pressing requirements for physicians trained in all recognized specialties. Each year the Army, Navy, and Air Force submitted a "shopping list" of their anticipated requirements for specialists for the next seven years. This list was drafted with the understanding that the physician being delayed for specialty training would not be available for duty until completion of that training. Participation was solicited during the last weeks of the senior year and selections were announced during the first weeks of the intern year. Participants stated their desire to enter active duty: (1) immediately after internship; (2) after a one-year delay; or, (3) after specialty training/^{they}expressed their ranked preference of component service. A random lot computer match of service requirements and applicant preferences was made. Those who matched received their first choice of service and/or term of delay by speciality. Those not matched had a second choice of: (1) choice of service; (2) one year delay; or, (3) withdrawal from the program with the understanding that the individual would be "taking his chances" with the draft. Participants were commissioned in an inactive reserve component of their sponsoring service and called to active duty upon expiration of the mutually agreed upon delay. The program was successful and was over-subscribed for most years of its operation. It enjoyed the confidence of both its

participants and the sponsoring services. The participant felt he had been given a fair and equitable chance at following his chosen course while the services could program an input of specialists trained at no expense to the government. As an added bonus, participants were assured that they would serve in their specialty on active duty upon completion of training.¹⁶

Upon termination of the draft, the Armed Forces Health Professions Revitalization Act of 1972 was enacted as PL 92-426. The Armed Forces Health Professions Scholarship Program is the second provision of this act. Participants are paid a monthly stipend of \$400, tuition and books, and are reimbursed for specified expenses related to their academic program. In addition, participants serve an annual 45 days on active duty as second lieutenants in the Army Reserve. This active duty period is similar to the active duty portion of the Clinical Clerkship Training Program discussed above. Upon graduation and completion of internship the participants serve one year on active duty for each year of subsidized education. Provisions are being developed by the services to permit delays from entry on active duty for completion of specialty training.¹⁷

Until passage of the scholarship program, the only program of fully subsidized medical education was the "Program for Medical, Osteopathic, Dental and Veterinary Education for Army Officers" expressed in Army Regulation

601-112. This program sends active duty officers to AMA or AOA approved schools. While in school they remain on active duty, drawing pay and allowances as well as tuition and book allowances. Originally designed to permit United States Military Academy Graduates to attend medical school, the program was expanded to include any regular Army officer and subsequently any active duty reserve officer. The author has observed that competition is intense; nevertheless, the program is extremely expensive and will be terminated in CY 1977. Need for this expensive program was obviated with the introduction of the Armed Forces Health Professions Scholarship Program.

OPPORTUNITIES FOR CONTINUED EDUCATION

The two major postgraduate programs of medical education are internship and residency. Current educational trends are changing to a continuum of the first and subsequent years of graduate medical education. The classic internship and residency pattern is more properly addressed at this time. The Army has offered both programs for many years. These programs and their procurement implications are discussed in Chapter II.

THE VOLUNTEER

The Army Medical Department has accepted volunteers since its inception. During the 1940-74 time period, little

was done to court the volunteer since any deficit in active duty requirements could be reconciled by increasing the next special draft call for physicians. When a special call for physicians was in effect, draft eligible doctors could volunteer only by requesting induction through their local boards. In effect, there were two categories of volunteers: (1) the draft eligible physician who elected to voluntarily enter active duty through his local board preempting the uncertainty of his inevitable induction date; and (2) the "pure" volunteer who had no service obligation by reason of age, prior service, sex, or nationality. The "pure" volunteer usually received a slight preference in assignment, although no formal program for volunteers was stated. Since the termination of the draft, all volunteers now fall in the "pure" category. The author has noted that there is still no formally stated, structured program to attract the volunteer.

In recent years an informal policy has emerged that permits the Surgeon General to invite prospective volunteer physicians to visit his office in Washington, D.C. at government expense. Once there, volunteers are interviewed by responsible senior Medical Corps officers and, if acceptable, mutually agreeable assignments are determined. This procedure is not advertised, but is effected through the Army Medical Department Personnel Counselors (See Chapter III). The volunteer is under no obligation to serve until he has formally executed his oath of office. The initial active duty period

is two years. There can be no negotiation of salary because military pay, allowances, and physician incentive pays are fixed by statute.

There has been a small, but steady, stream of volunteer physicians to enter the Army on their own initiative. Many have prior service experience and seek a return to a known and preferred life style. Below is a chart showing annual volunteer physician accessions from Fiscal Year 1969 through Fiscal Year 1974.¹⁸ During this period, there were no large scale or concentrated drives to recruit volunteer physicians.

MC VOLUNTEERS AS REFLECTED IN OFFICIAL ARMY REPORTS FY 69-74			
	<u>Volunteer Initial Tour</u>	<u>Prior Service</u>	<u>Total</u>
FY 69	70	13	83
FY 70	33	10	43
FY 71	30	8	38
FY 72	23	6	29
FY 73	114*	15	129
FY 74	36	22	48

*This figure is inconsistent with other years and with informal records maintained by the Officer Procurement Division. It is believed to be a computer error and probably accounts for another category of accession. Informal records indicate 30 volunteers in this category for FY 73.

The author has observed that the thrust of procurement efforts outside the draft has been through financial assistance or professional training. Little has been done to develop programs or to campaign directly for the attention of the service eligible physician for active commissioned service.

ENDNOTES

¹Journals of Congress, Vol. II, Resolution 14 June 1775 (Philadelphia, Pennsylvania R. Aitken, by order of Congress 1777).

²Maurice Berbary, The Physician, The Congress, The Armed Forces (Carlisle Barracks, Pa.: War College Thesis, 1969).

³U.S. Congress, Selective Service Act 1940, 76th Congress, 2d Sess., Pub. L.

⁴Time, "Lining Up the Doctors," May 11, 1942, pp. 58-59.

⁵"Impasse in Procurement and Assignments . . .," American Journal Public Health, XXXIII (January 1943), 73-75.

⁶William D. Tribble, Doctor Draft Justified? (San Antonio, Texas: National Bio Labs, 1968).

⁷U.S. Congress, Army, Navy, Public Health Service Medical Officer Procurement Act of 1947, Pub. L. 80-365, 80th Congress, 1st Sess., 1947; Selective Service Act of 1948, Pub. L. 80-759, 80th Congress; Amendments and the Selective Service Act of 1948 (Physician Amendment), Pub. L. 81-779, 81st Congress, 2d Sess., 1950.

⁸U.S. Congress, Selective Service Extension Act of 1950, PL 81-559, 81st U.S. Congress, 2d Sess., 1950.

⁹U.S., Congress, Amendments to Selective Service Act of 1948 (The Physician Amendment), Pub. L. 81-779, 81st Congress, 2d Sess., 1950.

¹⁰U.S., Congress, Universal Military Training and Service Act, Pub. L. 82-51, 82nd U.S. Congress, 2d Sess., 1951.

¹¹U.S., Congress, Amendments to Universal Military Training and Service Act, Pub. L. 83-84, 83rd Cong, 1st Sess., 1951.

¹²U.S., Congress, Further Amendments, Pub. L. 83-403, 82nd Congress, 2d Sess., 1954.

¹³Department of the Army, Early Commissioning Program, AR 601-140, 5 November 1971.

¹⁴Department of the Army, OTSG-MEMO Clinical Clerkship Training Program, GPO, Washington, D.C.

¹⁵Department of the Army, Medical, Osteopathic, Dental, and Veterinary Student Programs and Other Professional Training Programs, AR 601-130, 11 March 1971.

¹⁶Department of Defense, Berry Plan Booklets, Un-numbered Pamphlet. Issued annually. 1956-71, Washington: Government Printing Office.

¹⁷U.S., Congress, Armed Forces Health Profession Revitalization Act of 1973, Pub. L. 92-426, 92nd Congress, 2d Sess., 1972.

¹⁸Department of the Army, Working Papers, DASG-PDM dtd 7 January 1975, unpublished.

BACKGROUND READING

Department of the Army, DA Pam 20-212, History of Military Mobilization 1775-1945 (Washington, D.C.: Government Printing Office, 1955).

CHAPTER II

PROJECTED REQUIREMENTS FOR PHYSICIANS

PROCUREMENT PLANNING

The many variables of medical education, Army strength requirements and contractual terms of programs necessitate a procurement planning that realistically portrays the situation, yet can be adjusted as the situation warrants. Procurement must be conducted in an orderly consistent manner under the guidance of an overall plan and schedule. Planning should extend as far into the future as possible with the understanding that its accuracy diminishes the farther it is projected.

The Deputy Chief of Staff for Personnel (DCSPER) is responsible for overall procurement planning for the Army. Procurement planning is a continual process constantly updated as authorizations, available funds and the mobilization level of U.S. Forces change. The DCSPER advises The Surgeon General of the authorized strength of the Medical Corps and The Office of The Surgeon General is responsible for developing its Medical Procurement Plan.

Although the authorization is stated annually as a fixed figure, it may change several times in one year requiring

a continual recalculation of all procurement plans. There are a number of actions which can be taken to more equalize that figure with actual strength. Obviously, it is considered most desirable that the authorization be met by the end of the fiscal year. Overages can be decreased by promulgating a program of early release for obligated officers or by decreasing efforts at volunteer recruitment and postponing the entry on active duty of obligated officers wherever possible. Shortages can be reduced by encouraging extensions of active duty, emphasizing volunteer recruitment, or even reassessing requirements to determine if a possible reduction in requirements can be made that would better approximate the realistic procurement potential.

Due to the extensive lead time required for medical education, commitments for programs (such as the Armed Forces Health Professions Scholarship Program) are made many years in advance of anticipated entry on active duty. Because of this lead time and the statutory and contractual foundation for most commitments, changes in program strength may not be reflected in active Army strength for six or seven years. On the other hand, once a commitment is made, the Army is under strong pressure to bring the sponsored program participant to duty at the agreed time regardless of need. The author has observed that these factors tend to keep the estimates for sponsored programs conservative and reduce flexibility in the utilization of program "graduates."

THE MEDICAL PROCUREMENT PLAN 1975-80

The Surgeon General's medical procurement plan FY 75-80 is represented in Figures 1 and 2.¹ Figure 1 displays a procurement plan which assumes the authorized strength of the Medical Corps will not decrease after FY 76. Figure 2 presents a plan in which the strength of the Medical Corps decreases by two percent per annum consistent with recent overall decreases in the strength of the active army.¹

Both plans follow the same format with a year end authorization (line a), a year beginning strength (line b), and estimated losses and retention of obligors serving on their initial two year active duty term (lines c and d). The procurement objective (line e) is the heart of the matter and reflects the number of physicians required to meet the year end authorization. Subsequent lines show programmed gains (line f), the number of volunteers required (line g), and the estimated number of volunteers which can be procured (line h). The inventory of the Berry Plan (line i) is compared to the procurement objective (line j) and any Berry Plan Surplus is reflected (line k). The final line reflects any procurement shortfall, (line l).

Examination of both figures indicates that, assuming present conditions remain constant, the Army can satisfy its physician requirements with current programs and inventories through the end of FY 77, but will experience an increasingly serious shortfall in following years. This shortfall is

	75	76	77	78	79	80
a. Year-end Authorization	4512	4434	4434	4434	4434	4434
b. Beginning Strength	4503	4512	4434	4434	4434	4434
c. Losses	994	1186	1219	1166	1166	1166
d. Estimated Obligor Retention	67	138	190	178	178	178
e. Procurement Objective	936	970	1029	988	988	988
f. Programmed Gains	382	390	416	410	410	410
g. Volunteers Required	554	580	613	578	578	578
h. Estimated Volunteers	100	125	125	125	125	125
i. Berry Plan Inventory	776	625	511	157	50	50
j. Berry Planners Required to Meet Procurement Obj.	454	455	488	453	453	453
k. Berry Plan Surplus	322	170	23	0	0	0
l. Procurement Shortfall	0	0	0	296	403	403

FIGURE 1. Army Medical Corps Procurement Plan FY75-80
(Straight Lined At FY77 Authorization Level)

	75	76	77	78	79	80
a. Year-end Authorization	4512	4434	4345	4258	4173	4090
b. Beginning Strength	4503	4512	4434	4345	4258	4173
c. Losses	994	1186	1219	1166	1143	1122
d. Estimated Obligor Retention	67	138	190	178	174	171
e. Procurement Objective	936	970	940	901	884	868
f. Programmed Gains	382	390	416	410	410	410
g. Volunteers Required	554	580	524	491	474	458
h. Estimated Volunteers	100	125	125	125	125	125
i. Berry Plan Inventory	776	625	511	157	50	50
j. Berry Planners Required to Meet Procurement Obj.	454	455	399	366	349	339
k. Berry Plan Surplus	322	170	112	0	0	0
l. Procurement Shortfall	0	0	0	209	299	289

FIGURE 2. Army Medical Corps Procurement Plan FY75-80
(Reflects Annual 2 Percent Decrease in Authorization Level)

created by the exhaustion of the Berry Plan inventory and can only be reduced by increasing the number of volunteers. The input from other procurement programs is relatively fixed by proven program performance or by statute.²

The termination of the Berry Plan eliminates a valuable source of trained specialists. Once this input has ended the only programmed source of specialists available is the Army's own residency and fellowship programs. These programs provide specialists trained in Army facilities while serving as active duty officers. The number of Army residencies is restricted by the facilities available to support approved training curricula and the number of active duty spaces which can be "spared" for lengthy training periods. Medical officers in training are counted against the total Corps authorization as are medical officers on normal duty assignments. Army residency programs appear to be in good repute in the national medical community and there has been no difficulty in securing sufficiently well qualified applicants to permit an annual competitive selection. Participation in the residency programs is voluntary and applicants are attracted from both the active Army and the civilian professional community. It is interesting to note that the termination of the draft had no noticeable affect on the rate of applications for Army residency programs. However, the total product of Army residency programs is considerably less than the Army's requirement for specialists.²

The author has noted that individuals who have received Army Internship and/or residency training tend to remain on active duty as career or partial career officers; thus, these programs feed the cadre of the Regular Army Medical Corps.

ENDNOTES

¹Department of the Army, Working Papers, "The Procurement Plan 1975-80" (unclassified) DASG-PTP (Washington, D.C., 5 January 1975), unpublished.

²Interview with Colonel Dale R. Snyder, MC, Chief Officer Procurement Division, 31 December 1974.

CHAPTER III

THE ARMY MEDICAL DEPARTMENT PROCUREMENT SYSTEM

The Army Surgeon General is responsible for the procurement of professionally qualified officers for the six Army Medical Department Corps, i.e., Medical, Dental, Veterinary, Army Nurse, Medical Service, and Army Medical Specialists Corps. The procurement mission, excluding that of the Army Nurse Corps which is delegated to the U.S. Army Recruiting Command (USAREC), is assigned to the Officer Procurement Division of the Medical Personnel Support Agency, a field activity of the Office of the Surgeon General. The Officer Procurement Division is collocated with the Office of the Surgeon General in Washington, D.C., and functions as a staff division. Procurement functions include planning, program development, program management, national advertising and operation of field procurement activities.¹

THE ARMY MEDICAL DEPARTMENT (AMEDD)

PERSONNEL COUNSELOR

Seventeen AMEDD Personnel Counselors conduct field procurement activities throughout the United States.² An additional five Army Medical Specialist Corps officers serve as counselors in their fields of dietetics, occupational

therapy and physical therapy. Each counselor is responsible for a given geographic area and works from his regional field office(s). Counselors are college graduates who are active duty Medical Service Corps officers in the grades of captain or major. The author participated in the selection of counselors from 1971 to 1974 and observed that selected counselors have a background in military personnel and are carefully screened for demonstrated excellence in performance of duty, public speaking ability, and skill in relating with both the civilian and military professional communities. The officer's ability to perform isolated duty with little direct supervision is also considered. Once on the job he must stay abreast of current trends in professional education and have a good working knowledge of the Army Medical Department, especially the available career opportunities and training programs. No initial informal training is provided other than an overlap with his predecessor. An annual week-long training course for all counselors is conducted by the Officer Procurement Division staff to update the counselors' information and to allow an interchange of ideas and techniques. The course has a seminar format and relies heavily on the expertise available within the Office of the Surgeon General "faculty."

COUNSELOR FIELD OPERATIONS

The counselor in the field solicits applications for student and training programs through the medical school. A

visit is then scheduled and announced. The counselor may speak to a formal group arranged by the school, student interest group, or informal gathering. The visit is usually preceded by a mailout of materials germane to the program being presented. Subsequently the counselor helps the applicant prepare his application and monitors the student as he participates in the Army Program.

The solicitation of volunteer applications is not as completely structured as the student program applications and relies heavily upon coupon referrals, (coupon referrals are discussed in the advertising campaigns and materials section in this chapter) requests for applications, and information initiated unilaterally by the interested physician.

Care is taken throughout the process of soliciting and processing applications to make no promises or commitments which the Army cannot keep. The individual is advised of his probable eligibility for appointment and acceptability for active service.³ Consistent with public law and Department of Defense policy statements and guidelines, the appropriate commissioned grade of initial appointment is determined.⁴ Each applicant is given the opportunity to request the type of duty and/or location of his initial assignment. In many cases the initial assignment can be negotiated by the volunteer physician prior to acceptance of the appointment.

The counselor processes all applications for direct appointment and student program participation in his area.

There is no "quota" or "goal" system, although a pronounced decrease from past performance would be a reason for query from the Procurement Division. Each counselor has unrestricted telephonic communication with the Office of the Surgeon General and he is permitted to cross command lines for direct access to AMEDD agencies when pursuing information required by an applicant. Each field office is staffed with Civil Service clerical personnel and additional support may be provided by local medical or recruiting activities, e.g., reproduction services, clerical augmentation, office space, etc.

During the time of the active draft and an equally active Berry Plan, the counselor was operating at full capacity. A great deal of time was also spent in procurement activities for the Senior Medical and Osteopathic Student Program, the Early Commissioning Program, and the Clinical Clerkship Training Program, all of which are now either discontinued or significantly diminished. The counselor's major effort is currently directed at the Scholarship Program which has its annual peak from September through March.² Therefore, sufficient time appears now available to the counselor to permit expansion of his activities in recruiting volunteer physicians.

ADVERTISING CAMPAIGNS AND MATERIALS

The counselor's field activities are supported by a national advertising campaign. This advertising is supervised

and coordinated at the Officer Procurement Division. It is funded by USAREC and developed and produced (subject to approval of both USAREC and the Procurement Division) by N. W. Ayer and Sons, the Army contract advertising agency. The campaign includes conventional advertisements in professional publications, brochures and films. Full page advertisements are placed in professional publications, e.g., JAMA, New England Medical Journal, The New Physician and Black Bag, for either AMEDD training programs or a general solicitation for active service. Each advertisement is accompanied by a coupon which can be returned to the Procurement Division and forwarded to the appropriate regional counselor for direct contact with the respondent.

The author has observed that a successful effort to increase the professional quality of AMEDD advertising has been made in the past five years. One Army Medical brochure even earned a national advertising industry award and many others were nominated. It is difficult to attribute success or failure directly to advertising; however, the Army Medical Internship and Army Residency programs, both prime subjects for advertisements and commercially developed brochures in those 5 years, were filled or oversubscribed in each of those years. Obviously, these are respected programs for their own professional merits, but some of the success in procurement must be attributed to the advertising program.

Materials such as brochures, pamphlets and films are initially provided to the counselors based upon the potential

applicant density within their area. These commercially prepared materials are generally well executed and well received.

ATTITUDES

In the past, the draft was the mainstay of input into the Medical Corps and there was no real need to actively court volunteers. Consequently, little or no emphasis was given to volunteer programs or advertising for volunteers since any strength deficits could easily be made up by an increased Selective Service call.

The author observed that in the early 1970's many senior Medical Corps officers felt that to aggressively solicit volunteers in the medical manpower marketplace would compromise the Army's conservative image; therefore, there was a marked reluctance to promote any direct advertising or even a direct mail campaign.⁵

In late 1973 the author participated in an attempt to utilize a direct mail campaign. The N. W. Ayer account executive suggested the Army explore the possibility of utilizing direct mail techniques for physician procurement. The agency prepared a proposal and determined that mailing lists were available for purchase from the American Medical Association. The proposed materials were developed, reviewed, and tentatively approved for distribution by the Procurement Division. This marked a departure from customary advertising procedure and

an outline of the proposed campaign and materials was forwarded to the executive office of the Surgeon General for approval. In the meantime, the United States Air Force had fully implemented its own direct mail campaign. Some recipients of Air Force materials were active duty Army and Navy medical officers who indignantly brought the materials/^{to}the attention of their Surgeons General. Soon after the Army direct mail advertising proposal was reviewed at the executive office and summarily disapproved. The executive feeling, highlighting the conservative view, was that the campaign would be a potential source of embarrassment to the Army should a "recruiting flyer" be sent to an active officer of the sister services.

The author observed that the Army expends a great deal of effort to insure that AMEDD advertising is not misleading, is a factual presentation of opportunities available, and is ethically above criticism. Unfortunately, the structure and function of the Procurement Division, as well as the workload, do not include the staff or mission to analyze the long term effectiveness of advertising and procurement techniques.

In a direct mail campaign the agency purchases (or rents) lists of potential applicants from professional or other organizations and then prepares and forwards a letter and enclosed response card to each person listed. The lists are not completely accurate and it is impossible to be sure that all listed are eligible for service or to preclude mail-outs to current active members of sister services without

considerable refinement of the lists.

As a general guide it is considered in the profession that any materials accepted for publication by the JAMA magazine and its legal counsel and ethics committee are considered ethically acceptable by the profession.

ENDNOTES

¹Department of the Army, Army Medical Department Officer Procurement AR 601-132, 9 November 1973.

²Interview, COL Dale R. Snyder, MC, USA, Chief Officer Procurement Division and the author, 31 December 1974.

³Department of the Army, Appointment as Reserve Commissioned Officers for Assignment to the Medical, Dental, Veterinary and Medical Service Corps Branches of the Army Medical Department AR 135-101, 10 August 1966.

⁴Department of Defense, Temporary Grades and Authorized Strength in Grade of Medical and Dental Corps Officers (Assistant Secretary of Defense for Health and Environment), DOD Directive 1320.7, 7 August 1970.

CHAPTER IV

CIVILIAN PHYSICIAN PROCUREMENT

Little has been written about the civilian recruitment of physicians. The primary clearinghouse for such personnel transactions is the placement agency. To gain more insight into the operation of such an agency, an interview was conducted with a consultant in a successful agency specializing in medical manpower placements throughout the midwest. Much of this chapter reflects the content of that interview.¹

THE MEDICAL COMMUNITY TODAY

The medical community in the United States is currently in a state of turbulence. The trend for specialization coupled with the public's demand for more sophisticated care has created a top heavy professional pyramid with fewer general practitioners at the base. Concurrently, the burgeoning role of the various health insurance companies with their coverage restrictions on the physicians and the legislatively imposed sanctions of "peer review" have inhibited many physicians in their sincere desire to practice good medicine.^{2,3}

Within the past six months a national medical crisis has surfaced over the issue of malpractice insurance.⁴ Many physicians in the "riskier" specialties find themselves unable

to secure insurance or are forced to pay premiums which erode their net income. This crisis came unexpectedly and little serious study has been given to possible solutions, although it appears that congressional action will be required to restore some degree of normality to the system.⁵

Other problems are faced in the distribution of physicians outside the major metropolitan areas. The concept of a "physician's assistant" to extend the hands of the general practitioner has been applauded and partially implemented, but the legal and ethical problems of liability and responsibility have not been resolved.³

Fewer physicians are entering private practice and the trend is toward corporate medicine or the group practice with a small number of physicians in related professional areas incorporated as a business and employed by their own corporation. The group practice has distinct tax advantages as well as permitting the employ of paraprofessional supporting personnel which is not feasible in private practice.²

THE PLACEMENT AGENCY

Medical facilities have traditionally conducted their own procurement activities; however, a growing number employ a placement agency concentrating on health professionals. Many professionals wishing to change their employment or improve their opportunities seek the services of such an agency. Some agencies specialize in specific areas of medicine

while others are more general and deal in clients and facilities with requirements and skills at all levels within the health care disciplines. The agencies receive a fee which is a percentage of the placed individual's first year's base pay. The fee ranges from 10-30 percent with 20 percent being the norm. It is normally paid by the facility hiring the physician. Most agencies maintain a high standard of ethical practice. In such a competitive business the unethical firm usually fails.

"Recruiters" employed by the agencies are usually college graduates with a personnel, business, or scientific background. Knowledge of medical economics and training patterns is acquired as needed to relate to clients.

TECHNIQUES AND MATERIALS

After receiving a contract from an individual or facility, the agency first attempts to match the requirement from within its own files. If this is not successful, it may screen advertisements and other cooperating agencies which operate on a stipulated split fee basis. If this search is unproductive, a direct mail approach to potential employees/employers with the requisite qualifications is made. Referrals may be solicited from individuals who were previously placed by that agency; however, the ethical agency usually maintains a one year "hands off" policy on formerly placed individuals to preclude the image of promoting job-

skipping or undermining the employer in retaining competent employees.

Once an alignment of employee-prospective employer is made the agency can either act as its client's agent to negotiate salary, benefits, etc., or place the client in direct contact with the hiring facility or individual.

The placement agency conducts very little personal "field" operations and relies heavily on telephonic communications, direct mail, and personal referrals. Agencies use few printed materials other than those provided by their facility-client describing the firm or locale. Advertisements placed by agencies may be in behalf of their client or announcements of the services available through the agency. Generally, these advertisements are in the classified sections of professional publications.

INCENTIVES

The physician's salary is established as a flat rate based upon his level of professional achievement, or; as a percentage of practice net income, or, a combination of both. Salary is but one benefit; additional incentives include stock option plans, housing, leased automobile, programmed promotions or salary increases, complete or partial payment of malpractice, and other insurances and a comprehensive retirement annuity program. As in any other industry, the governing factor in salary determination is supply and demand.

PRODUCTIVITY

There are no meaningful figures available to evaluate the success of placement agencies; however, it must be presumed that the agencies are, to some degree, successful or they would fail as a business venture. The agencies' income is the successful placement fee.

CONCLUSIONS

Civilian procurement is an example of a service capitalizing on the free enterprise system. It assists the client in the market place to best meet his professional needs and aspirations. In general, the civilian agency conducts its business ethically and with dignity. The civilian agency is more personalized and actively seeks referrals and placement positions while the Army has been more willing to let the prospective applicant "sell himself" on the Army and take the first step in initiating his application. Civilian agencies acquaint prospective clients with available opportunities and offer their services.

ENDNOTES

¹Interview with Mr. Bill McWilliams, consultant to Technical Personnel Exchange, a placement agency located in Kansas City, Missouri, dealing primarily with the health professions. The interview went beyond the operations and policies of Technical Personnel Exchange to discuss practices, techniques and conditions common in the professional placement business.

²Newsweek, "Doctor's New Dilemma," February 10, 1975, pp. 41.

³U.S. News, "How Good Is Your Doctor?" December 23, 1974, pp. 46-53.

⁴U.S. News, "Lawsuits-A Growing Nightmare for Doctors" January 20, 1975, pp. 53-4.

⁵Business Week, "Way to Clean Up The Malpractice Mess," February 24, 1975, pp. 30.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

Current Army procurement plans and policies are adequate to provide sufficient physicians for active Army service through fiscal year 1977. Any deficit in volunteer physician procurement is offset by the Berry Plan. However, the inventory of Berry Plan participants will be dramatically exhausted in FY 1977 and an annual shortfall of approximately 300 physicians per year can be expected for the remainder of the decade (see Chapter II, figure 2). It is extremely doubtful that current procurement programs will recruit sufficient volunteers to meet this projected shortfall. This can be attributed directly to the current lack of any concentrated effort by the Army to attract the volunteer. Although administrative procedures already in effect are sufficient to support any increased recruitment efforts, there is an apparent reluctance to utilize contemporary marketing techniques as a means to assist in the procurement of the volunteer physician.

Current training programs are filled to the capacities set by statute and good management. However, the projected

shortfall is created not by deficits in training programs but by the loss of the main source of trained physicians prepared to enter the Army ready to go to work --The Berry Plan. Volunteers must be sought from among specialized and un-specialized physicians who can immediately be on the job delivering primary health care after entering the Army.

It is desirable, as first priority, to obtain younger physicians who are completely finished with their training and have the potential for serving a full career. The logical time and place to attract these individuals is in their final months of training at their teaching hospital. Another prime group eligible for solicitation is those who have recently completed their specialty training, but are in an affiliated practice without a deep personal and financial commitment to a private "solo" practice. An equally high priority should be given to those physicians who have recently (within 12-18 months) left active military service and may still be un-entangled in the web of private practice. Any of these three groups of physicians, if attracted to serve, can be effectively employed in the Army medical system within six weeks following entry on active duty.

Little can be directly gained from observing the civilian employment agency except to note the persistence, if not aggressiveness, in making initial personal contacts with potential clients and the general acceptance of these activities as being ethical techniques. The Army's efforts to maintain

its own absolute standard of "ethical" procurement, especially in the area of advertising, has led to conservatism and hypersensitivity to any criticism of Army recruiting methods. This attitude probably stems from the era of the active draft when efforts to recruit volunteers might have been perceived as frivolous or wasteful to the medical community since Army manpower problems were inevitably resolved by the draft.

Current policies such as the visitation program with its "free" trip to Washington, D.C. are productive and take advantage of the Army's organizational structure and worldwide assignment capabilities. This policy does reflect a willingness to try, albeit on a small scale, an innovative procurement technique. Unfortunately, further new methods of recruiting have not been tried.

The potential for advertising, for example, has not been fully exploited, although the resources available are more than adequate. A great opportunity for direct mail appeals is untapped. Those commercially prepared brochures, pamphlets and films in current use are of good quality, generally coordinated, and proven to be well received. The next logical step would be the commercially developed direct mail appeal. The rejection of the proposed direct mail campaign for fear of criticism from a sister service illustrates the conservative attitude now existing in the Surgeon General's Office toward innovative methods in recruiting.

The Army can offer: (1) security; (2) regular working hours; (3) fixed vacation with pay; (4) opportunities for professional development; (5) travel; (6) an excellent comprehensive retirement program; (7) adequate income; (8) the opportunity to practice good medicine without consideration of the patients ability to pay; (9) the use of good equipment, facilities, and ancillary staff without cost to the physician; (10) malpractice liability borne by the government at no cost to the physician; and, (11) an opportunity to gain the intangible satisfaction found in "serving one's country." All these advantages of Army service can be effectively presented to attract the potential physician volunteer. If presented imaginatively to the current turbulent medical community, the Army should prove to be a most effective competitor in the civilian personnel marketplace.

Although the Army has a potentially effective system for soliciting and processing applications, this system is not being utilized to the maximum. The AMEDD counselor is responsive, well organized, supported, and oriented toward physician procurement; but, neither he nor the procurement system is directed toward the volunteer. Present circumstances indicate that personnel and time resources are available to expand volunteer physician procurement activities within existing capabilities.

It is time to cast aside the extreme conservatism of the draft era. The comprehensive programs which maximized

the benefits of the draft to provide a variety of inputs, including needed specialists, were excellent. They were wisely discontinued in proper order upon expiration of the draft. A comprehensive program for volunteer recruitment now must be devised and marketed to offset the loss of the draft programs. The ingredients of a product and merchandising system is available; all that is needed is development and sales. The Army must be competitive in its physician recruitment efforts if it is to maintain the minimum strength necessary to provide its own health care. It must be contemporary and willing to present its case and image for a comparison of the advantages and disadvantages of Army service with other options available to the potential volunteer.

RECOMMENDATIONS

A comprehensive market analysis needs to be conducted, either within the assets of the Office of the Surgeon General or by contract to a civilian firm specializing in analysis, to determine the most marketable options permitted under existing law that can be presented as recruitment incentives. These incentives should present an array of options and be coordinated with Army needs to develop a definitive recruiting program. For example, the 11 "advantages" presented above coupled with a guaranteed assignment could be "packaged" as one option offering. The individual is concisely told why he should join the Army and offered a further incentive to do so

(the guaranteed assignment). Properly publicized this could be an attractive offering yet would require no change or deviations from current regulation and statute.

Once developed, the program(s) should be advertised, within ethical good taste, to as many potential volunteers as possible. Techniques should include national advertising, direct mail, and, where possible, counselor visits.

Obviously the Army Medical Department faces a serious procurement problem. Many of the resources necessary to alleviate this problem are already at hand and can be easily used. The Army must squarely face its civilian competitors and enter the marketplace for medical manpower with the same proficiency and aggressiveness with which it has addressed other fields and assigned missions.

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